



Pinehurst Medical Clinic

Location: «ApptLocDesc»
Pinehurst Medical Clinic Pulmonology - Pinehurst
205 Page Road, Pinehurst, NC 28374

RE: Appointment Date: «ApptDate»
Appointment Time: «ApptTime»
Provider: «ApptResName»

«PFirst» «PLast»
«PStreet1»
«PCity», «PState» «PZipCode»

Dear «PFirst» «PLast»,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic Pulmonology - Pinehurst. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 15 minutes prior to the scheduled time of your appointment to avoid delays.
2. Bring your medical insurance card(s) and medications with you on the day of your appointment. To find a list of PMC's contracted payers or to review additional insurance information, please visit pinehurstmedical.com/resources-category/insurance
3. If previous medical records are needed our office may contact you to make arrangements to obtain records.
4. If you are a new patient being seen for pulmonology issues and have had any recent testing or imaging done **outside the FirstHealth system**, please bring copies of those records and the CD discs of the imaging to your appointment. *If you are being referred to us for an abnormal CT scan, you **must** bring a copy of the CT scan on a CD disc.*
5. Once you've established care, for urgent needs after hours, please call the office and follow the instructions to reach the provider on call.

*Pinehurst Medical Clinic Pulmonology & Sleep Medicine kindly ask you and anyone coming with you to your appointment to **refrain** from wearing scented lotions, perfumes, and/or cologne as many of our patients are sensitive to these products. If you or any persons with you do not adhere to this policy, you may be asked to reschedule.*

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Pulmonology
(910) 295-9359

REGISTRATION FORM
PATIENT INFORMATION

Patient's Name:		
Address:		
City:	State:	Zip Code:
Home Phone:		
Mobile Phone:		Other Phone:
Patient e-mail:		
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown		
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student <input type="checkbox"/> Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	State:	Zip Code:
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	Effective Date – From:
Subscriber Name:	Patient's Relationship to Insured:
Subscriber SSN:	Subscriber's DOB:
Subscriber Employer:	Subscriber's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

NEW PATIENT QUESTIONNAIRE
Pulmonary & Sleep Medicine

Patient Name: _____ Date: _____
Date of Birth: _____

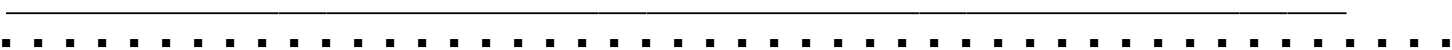
Referring Provider: _____

Primary Care Provider: _____

You are scheduled for a Pulmonary (Lung) issue with _____

You are scheduled for a Sleep Medicine issue with _____

What is your main lung or sleep problem?



Marital status: Single Married Divorced Widow

Occupation: _____ **Retired:**

Education Level: _____

Leisure Activities – Hobbies: _____

Medical History:

Please list current medical conditions or past illnesses ***you*** are being/have been treated for:

I have no current diagnosed medical conditions

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Chest pain/heart attacks | <input type="checkbox"/> A-fib/Flutter | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Heart Valve Ds/Murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Ear Infections <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Previously diagnosed with Sleep Apnea <input type="checkbox"/> COVID-19 | | |
| <input type="checkbox"/> If you have Sleep Apnea, are you currently using a CPAP machine? _____ | | |

Other conditions:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Surgical History: Please list any operations **you** have had.

I have never had any surgeries

- Gall Bladder Appendix Tonsils Ear Tubes
- Heart Bypass Heart Valve Pacemaker/Defibrillator Vascular Surgery
- Back Hip Knee Shoulder
- Lung biopsy Lung Removal Bronchoscopy

Other Surgeries:

- 1. _____ 3. _____
- 2. _____ 4. _____
- 5. _____ 6. _____

Family History: Please check if any close **family members** have any of the following:

- Cancer Father Mother Siblings Kids _____
- Lung problems Father Mother Siblings Kids _____
- Heart Problems Father Mother Siblings Kids _____
- Blood Clot Problems Father Mother Siblings Kids _____
- Sleep Problems Father Mother Siblings Kids _____
- High Blood Pressure Father Mother Siblings Kids _____
- Diabetes Father Mother Siblings Kids _____

Other Problems? _____ Who/What: _____

Medications you are currently taking & drug dosage/frequency of each: Please include any Over-the-Counter meds.

I'm currently not taking any prescribed medications

- Albuterol (Proair, Proventil, Ventolin, Xopenex) Atrovent Combivent
- Flovent Arnuity Asmanex Pulmicort Qvar Alvesco Aerospan
- Advair Breo Symbicort Dulera Nebulizer: _____
- Serevent Striverdi Arcapta Spiriva Incruse Tudorza Seebri
- Anoro Stiolto Bevespi Utibron Singulair Daliresp Prednisone
- Theophylline Flonase/Nasonex Claritin/Zyrtec/Allegra Omeprazole/Nexium/Prilosec

Others:

- 1. _____ 10. _____
- 2. _____ 11. _____
- 3. _____ 12. _____
- 4. _____ 13. _____
- 5. _____ 14. _____
- 6. _____ 15. _____
- 7. _____ 16. _____
- 8. _____ 17. _____
- 9. _____ 18. _____

Allergies to Medications:

I have no known allergies to medications

- 1. _____ 3. _____
- 2. _____ 4. _____

Vaccinations: last given?

- Flu Shot: _____
- COVID-19: _____
- Pneumonia: Pneumovax (23): _____ Pevnar (13): _____

Social History

Smoking Status:

- Never
- Years Smoked: _____ Age started _____ Packs per day: _____
- Date Quit _____ / _____ months/years ago
- Lived with someone who smoked: #Years _____

Alcohol consumption: None Drinks per day: _____ Week: _____

Caffeine consumption: None Drinks per day: _____ Week: _____

Occupational History: Have you ever worked around or been exposed to the following:

- Asbestos: Silica or Coal dust Furniture/Saw Mills
- Cotton or Textile Mills: Welding fumes
- Toxic/Industrial Chemicals: _____
- Someone with ACTIVE tuberculosis "TB"

Current Pets: Cats Dogs Birds Other: _____

Please mark any symptoms you are having now or in the "recent" past.

General Health **No Symptoms**

- Fever Malaise/no energy No appetite
- Shaking chills Fatigue Drenching night Sweats
- Recent weight Loss

Ear Nose & Throat: **No Symptoms**

- Sore throat Nasal congestion Ear ache
- Scratchy throat Nasal discharge Loss of hearing
- Hoarseness Sneezing White patches in mouth
- Nosebleeds Snoring Sinus pain
- Visual changes Eye symptoms Stop breathing in sleep

Cardiovascular: **No Symptoms**

- Chest Pain Racing heart Leg Edema
- Palpitations Light headedness

Pulmonary: **No Symptoms**

- | | | |
|---|---|--|
| <input type="checkbox"/> Short of breath (SOB) | <input type="checkbox"/> Cough | <input type="checkbox"/> Clear sputum |
| <input type="checkbox"/> Wheeze | <input type="checkbox"/> Dry cough | <input type="checkbox"/> Colored sputum |
| <input type="checkbox"/> Productive cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> SOB worse lying down |
| <input type="checkbox"/> Unable to cough up sputum | <input type="checkbox"/> Coughing when eating | <input type="checkbox"/> Chest pain with breathing |
| <input type="checkbox"/> Sleeping upright/Extra pillows | <input type="checkbox"/> Awakening at night SOB | |

Gastrointestinal - Stomach & Bowels: **No Symptoms**

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bright Red Blood per Rectum |
| <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Melena/black-sticky stool |
| <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting blood |
| <input type="checkbox"/> Unable to pass flatus | | |

Urinary: **No Symptoms**

- | | |
|--|--|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Suprapubic pain |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Urinary urgency | <input type="checkbox"/> Dark urine |
| <input type="checkbox"/> Flank pain | <input type="checkbox"/> Blood in urine |

Female Specific

- | |
|--|
| <input type="checkbox"/> Foul smelling vaginal d/c |
| <input type="checkbox"/> Missed menstrual period |
| <input type="checkbox"/> Suspected pregnancy |
| <input type="checkbox"/> Menstrual pain |

Male Specific

- | |
|---|
| <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Urinary hesitancy |
| <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> Testicular pain |

Musculoskeletal: **No Symptoms**

- | | | |
|--|--|---|
| <input type="checkbox"/> Diffuse joint pain | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Pain in other joints |
| <input type="checkbox"/> Muscle ache generalized | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Back muscle spasm | |

Skin & Breasts: **No Symptoms**

- | | | |
|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Erythema | <input type="checkbox"/> Nodule |
| <input type="checkbox"/> Lesions | <input type="checkbox"/> Edema | <input type="checkbox"/> Plaque |
| <input type="checkbox"/> Wound | <input type="checkbox"/> Scaling | <input type="checkbox"/> Papule |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Blister | <input type="checkbox"/> Pustule |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Breast pain | <input type="checkbox"/> Pain w/o rash or sore |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Patch | <input type="checkbox"/> Breast lump |

Neurologic: **No Symptoms**

- | | | | |
|------------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Paresthesia/pins & needles | <input type="checkbox"/> Leg Weakness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Saddle paresthesia | <input type="checkbox"/> Tingling | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg numbness | <input type="checkbox"/> Difficulty walking | |

IMPORTANT

If you've had **CT Scans** and/or **Chest X-rays** please bring the CD-ROM disk to your appointment.

You will not need the disk if you had these done at the following:

FirstHealth of the Carolina – all hospitals and clinic locations

Pinehurst Surgical Clinic

Scotland Memorial Hospital

Valley Regional Imaging

Pinehurst Medical Clinic

Sleep Questionnaire

Do you snore? Yes No Don't know

 If yes, is it loud? Yes No Don't know

How long ago did it start? _____

months/years Is it worsening? Yes No

Don't know

In which positions do you snore? Back only All positions

Is your snoring worse on your back? Yes No Don't know

Do you snore if you fall asleep in a chair? Yes No Don't know

Does your snoring disturb anyone? Yes No Who? _____

Has anyone ever noticed if you stop breathing in your sleep? Yes No

Do you ever wake yourself from sleep with your snoring, gasps or feeling choked? Yes No

Do you suffer from either of the following in the morning? Dry mouth Headaches Neither

Do you feel sleepy during the daytime? Yes No

 If yes, how many days per week? _____

 When did it start? _____ months/years

 Is it worsening? Yes No Don't know

Have you ever felt sudden loss of strength in response to emotional experiences? Yes No

Have you ever felt paralyzed when you first wake up or when falling asleep? Yes No

Have you ever had vivid or menacing visions just before falling asleep? Yes No

Do you walk in your sleep? Yes No Don't know

Do you talk in your sleep? Yes No Don't know

Do you have nightmares? Yes No

Do you ever accidentally urinate in bed? Yes No

What time do you generally go to bed? _____ pm/am Wake up? _____ am/pm

How long does it usually take for you to fall asleep? _____ minutes? _____ hours?

How many times do you wake up in the middle of the night? _____

Are you able to fall back to sleep easily after these night awakenings? Yes No Not always

EPWORTH Sleepiness Scale: Please rate your **chance of dozing** in following situations.

- 0 – NEVER dose
- 1 – SLIGHT chance
- 2 – MODERATE chance
- 3 – HIGH chance

- ___ Sitting & reading
- ___ Watching TV
- ___ Sitting inactive in public
- ___ Passenger in a car w/o break
- ___ Laying down to rest in afternoon
- ___ Sitting & talking to someone
- ___ Sitting quietly after lunch w/o alcohol
- ___ In a car, stopped in traffic for a few minutes

Have you ever had a traffic accident or “close call” while driving because of sleepiness?

Yes No

Do you suffer from memory problems? Yes No

Do you take any daytime naps? Yes No

How many per week? _____ How long do you nap on average? _____ Minutes

Are the naps refreshing? Yes No

Rate the severity of your daytime sleepiness on a scale of 1 to 10. _____

Do you ever experience restlessness or discomfort in your legs, especially in the evenings? Yes No

Does it interfere with sleep? Yes No

Do you move or kick your legs while sleeping? Yes No don't know

IMPORTANT

If you had a **Sleep Study** at another facility, **please bring copies of the study** with your have reports faxed to:

Fayetteville (910) 420-1618 Pinehurst (910) 235-3401 Sanford (919) 292-1205

Pinehurst Medical Clinic Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that apply:

- All of my medical information
- Information necessary to schedule appointments for me
- Lab or test results
- Information necessary to provide, call in or pick up prescriptions for me
- Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at Pinehurst Medical Clinic, unless and until I notify Pinehurst Medical Clinic in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to patient: _____

Account # _____

Patient Acknowledgment and Authorization

Please initial each section and sign to indicate acknowledgment and authorization.

Patient Payment Policy

I have read and understand the Pinehurst Medical Clinic, Inc. Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

Notice of Privacy Practices

I understand that Pinehurst Medical Clinic, Inc. will use and disclose my/the patient's health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

Assignment of Insurance Benefits

I authorize the payment of medical benefits to Pinehurst Medical Clinic, Inc., and hereby assign to Pinehurst Medical Clinic, Inc. and the professionals involved in my/the patient's care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

Consent to Treat

I, the Patient/the Patient's Legal Representative, hereby grant permission to Pinehurst Medical Clinic, Inc., and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment.

Patient Rights and Responsibilities

I understand that I have the right, and the responsibility, to participate in my/the patient's care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my/the patient's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that the Pinehurst Medical Clinic health care providers will treat me with respect, and I agree to do the same for them.

Patient Name (printed): _____**Patient/Legal Guardian Signature:** _____ **Date:** _____

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are \$75 for a new patient office visit, \$25 for an established patient office visit, and \$25-\$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9392. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information:
<https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/>
14. Failure to pay a balance due promptly may result in one or more of the following:
 - a. Your account may be referred to a collection agency,
 - b. Your past due status may be reported to the applicable credit bureaus,
 - c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327-3159.



Pinehurst Medical Clinic

Access Your Health Information Online

Where you need it, when you need it.

Powered By FollowMyHealth

An all-in-one personal health record & patient portal that lets you access your health information online & on the go!



View test & lab results



Receive email care reminders



Send & receive secure online messages



Request appointments



Request Rx refills



Set up proxy accounts for children & dependent adults

To get started with a new account, give receptionist your email. To log in to an existing account, scan below.



Questions?

Call (910) 235-3380 or email fmhsupport@pinehurstmedical.com